STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175385	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARAMOUNT COMMUNITY LIVING AND REHAB INC	**200 SW 14TH , NEWTON, Kansas, 67114**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The following citations represent the findings of complaint investigation(s) 3170544 and 3108067. The census was 96. The sample included four residents.	F0000		
F0726 SS = E	Competent Nursing Staff CFR(s): §483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is NOT MET as evidenced by:	F0726		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175385	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARAMOUNT COMMUNITY LIVING AND REHAB INC	**200 SW 14TH , NEWTON, Kansas, 67114**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0726 SS = E	Continued from page 1 Based on interviews, observations and record review, the facility failed to ensure Certified Nurse Aide (CNA) N possessed the appropriate competencies to provide nursing and related services to dependent residents to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial wellbeing. Findings Included: - Review of the Electronic Health Record (EHR) documented Resident (R)1 had diagnoses that included spastic quadriplegic (inability to move the arms, legs, and trunk of the body) cerebral palsy (a progressive disorder of movement, muscle tone, or posture caused by injury or abnormal development in the immature brain, most often before birth). R1's 06/29/2026 "Admission Minimum Data Set" (MDS) documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The assessment documented R1 was frequently incontinent of urine and always incontinent of bowel and was dependent on staff for all cares except showers or bathing, which required substantial to maximum assistance. R1 was dependent on staff for all transfers and was independent with locomotion with his motorized wheelchair. R1 was non-verbal, but able to make himself understood by others. R1's 06/29/2026 "Communication Care Area Assessment" (CAA) was not triggered. R1's 06/29/2026 "Activity of Daily Living (ADL) Functional / Rehabilitation Potential CAA" documented R1 needed daily assistance with activities of daily living (ADL) and identified spastic quadriplegic cerebral palsy as the contributing factor. During an observation on 09/01/2026 at 10:35 AM, R1 was in his wheelchair in his room and interacted appropriately with staff and communicated with a computerized pad where he spelled out his needs and desires. On 09/01/2026 at 08:00 AM, Administrative Staff A and Administrative Nurse D identified that R1 lived in the "405" house on the campus. Additionally, Administrative Staff A and Administrative Nurse D identified "405" house currently contained nine residents. Further, Administrative Staff A and Administrative Nurse D identified CNA N worked in the "405" house and "1215" house (which currently	F0726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175385	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARAMOUNT COMMUNITY LIVING AND REHAB INC	**200 SW 14TH , NEWTON, Kansas, 67114**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0726 SS = E	Continued from page 2 contained eight residents) and stated the night shift was from 10:00 PM to 06:00 AM and there was one CNA staff member in the building to provide cares with a nurse on the campus that was available if a second staff member was needed or required. Administrative Staff A and Administrative Nurse D provided documentation that indicated CNA N had orientation shifts on 08/06/2026, 08/07/2026, 08/10/2026, and 08/13/2026. CNA N worked without direct supervision on 08/14/2026, 08/15/2026, 08/16/2026, and 08/18/2026. On 09/01/2026 at 10:36 AM, R1 indicated, with his computerized communication device, that he felt safe in the facility now and that there had been one staff member who had been rough with him during cares. He could not remember the specific details of when. On 09/01/2026 at 01:20 PM, Certified Medication Aide (CMA) R reported that on the morning of 08/19/2026, when R1 was getting up and she and CNA M were assisting with morning cares with Licensed Nurse (LN) G in the room, R1 was agitated and he indicated that the overnight CNA had been rough when she provided cares during the night. LN G was in the room and was aware of the concern expressed by R1. On 09/01/2026 at 02:00 PM, LN G reported that on the morning of 08/19/2026, she was in R1's room administering his morning tube feeding (administration of nutritionally balanced liquefied foods or nutrients through a tube) and medication administration, and CMA R and CNA M were providing morning cares and assisted R1 in getting ready for the day. R1 gestured and indicated a staff member had been rough with changing his brief overnight. LN G stated that she notified Administrative Nurse E of the situation and allegation when she arrived. On 09/01/2026 at 02:45 PM, Administrative Nurse E stated that on the morning of 08/19/2026 at an unknown time, she was notified by LN G of an allegation about CNA N's treatment of R1 during the overnight shift. Administrative Nurse E reported that she spoke with R1 and then passed the concerns on to Administrative Nurse D and Administrative Staff A for investigation. Administrative Nurse E identified CNA N as a new CNA and a new employee of the facility. Administrative Nurse E stated she was involved in a meeting on the afternoon of 08/17/2026 where CNA N was provided coaching and the expectations from management were outlined. This coaching session was a result of	F0726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175385	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARAMOUNT COMMUNITY LIVING AND REHAB INC	**200 SW 14TH , NEWTON, Kansas, 67114**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0726 SS = E	Continued from page 3 concerns that were identified by other CNA staff and CMA staff, where CNA N had left R1 and other residents in soiled briefs at the end of her shift. Administrative Nurse E stated that they had received complaints from CMA and CNA staff that indicated that staff had received complaints from residents that CNA N was loud in the house at night, which made it difficult for the residents to sleep. On 09/02/2026 at 10:23 AM, Administrative Nurse D identified CNA N as a new employee for the facility and a new CNA, and revealed she had received concerns from CNA and CMA staff that CNA N had left R1 and other residents in soiled briefs at the end of her shift and had been on her personal cell phone while on duty. Administrative Nurse D discussed a meeting that occurred on 08/17/2026 at approximately 02:00 PM, where Administrative Staff C, Administrative Nurse D and Administrative Nurse E met with CNA N to discuss concerns that had been brought to the attention of management from other CNA and CMA staff about CNA N's job performance related to the lack of cares provided to R1 and other residents. Administrative Nurse D stated CNA N came to the meeting with a defensive attitude and became verbally aggressive when confronted with the concerns. Administrative Nurse D stated CNA N claimed to have insufficient training and orientation. Administrative Nurse D and Administrative Nurse E offered to provide additional training and orientation; however, CNA N verbally refused. Administrative Nurse D notified the staffing team (CNA O and CMA T) to provide an additional orientation shift on 08/17/2026. Administrative Nurse D stated that during the morning standup meeting on 08/18/2026 at an unspecified time, she was notified that CNA N had refused the additional orientation shift on 08/17/2026 and had left the property. Administrative Nurse D confirmed CNA N was allowed to work on 08/18/2026 from 10:00 PM to 06:00 AM without having completed additional training shifts. Administrative Nurse D stated that she was notified by Administrative Nurse E on 08/19/2026 at 08:24 AM of an alleged incident that involved CNA N's care of R1. Administrative Nurse D and Administrative staff A went to the "405" house to interview R1 and initiate the investigation. CNA N was confirmed not to be on the property and was suspended pending the outcome of the investigation. On 09/02/2026 at 02:50 PM, Administrative Nurse D stated that she expected staff to have notified her immediately that CNA N refused the orientation shift so that appropriate actions could have been taken. The facility's "Training Requirements" policy, dated	F0726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175385	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARAMOUNT COMMUNITY LIVING AND REHAB INC	**200 SW 14TH , NEWTON, Kansas, 67114**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0726 SS = E	Continued from page 4 01/2024, documented that the facility would develop, implement, and maintain a training program for all new and existing staff consistent with their expected roles. The policy documented that it was the responsibility of the employee to complete the required training, and the facility would offer a variety of training methods to accommodate individuals and if an individual failed to complete required training, it could result in termination of employment. The facility's "Required Training, Certification and Continuing Education of Nurse Aides" policy, dated 01/2024, documented that the facility would comply with State and Federal regulations and requirements as they pertained to training of nurse aides. The policy documented that in-service training would be provided based on the needs of the residents and any areas of weakness as determined in the nurse aide's performance.	F0726		